907 KAR 1:013 and E
Material Incorporated by Reference

# Medicaid Reimbursement Manual for Hospital Inpatient Services

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TABLE OF CONTENTS


| | | Page |
|---|---|---|
| Section 1: | Introduction | 1.1 |
| Section 2: | Reimbursement for Acute Care Services in Acute Care Hospitals | 2.1 |
| Section 3: | Outlier Payments | 3.1 |
| Section 4: | Transfers | 4.1 |
| Section 5: | Reimbursement for Rehabilitation Services in an Acute Care Hospital | 5.1 |
| Section 6: | Reimbursement for Inpatient Psychiatric Services in Acute Care Hospitals | 6.1 |
| Section 7: | Budget Neutrality | 7.1 |
| Section 8: | Reimbursement Updating Procedures | 8.1 |
| Section 9: | Payment for Rehabilitation Hospital, Long-term Acute Care Hospital, and Psychiatric Hospitals | 9.1 |
| Section 10: | Payment for a Critical Access Hospital | 10.1 |
| Section 11: | Reimbursement for Out-of-State Hospitals | 11.1 |
| Section 12: | Supplemental Payments | 12.1 |
| Section 13: | Disproportionate Share Hospital Classification | 13.1 |
| Section 14: | New Providers, Change of Ownership, or Merged Facilities | 14.1 |
| Section 15: | Unallowable Costs | 15.1 |
| Section 16: | Cost Reporting Requirements | 16.1 |
| Section 17: | Access to Subcontrator's Records | 17.1 |
| Section 18: | Audit Function | 18.1 |
| Section 19: | Retrospective Review | 19.1 |
| Section 20: | Reimbursement Review Appeal Procedures | 20.1 |
| Section 21: | KCHIP or Medicaid Screening Form DSH-001 | 21.1 |

# SECTION 1. INTRODUCTION

## Section 1. Introduction

A prospective payment system for hospitals providing inpatient services for Medicaid recipients, to be reimbursed under the Kentucky Medicaid Program (program) for the Department for Medicaid Services (department), is presented in this manual. If not otherwise specified, this system utilizes allowable cost principles of the Title XVIII (Medicare) Program. This payment method is designed to achieve two major objectives: 1) to assure that needed inpatient hospital care is available for eligible recipients and indirectly to promote the availability of this care of the general public, and 2) to assure program control and cost containment consistent with the public interest. Under this system, payment shall be made to facilities on a prospective payment system for inpatient care. Except as otherwise indicated in this Medicaid Reimbursement Manual for Hospital Inpatient Services, the basis of this prospective payment shall be a per discharge methodology.

## SECTION 2. REIMBURSEMENT FOR ACUTE CARE SERIVCES IN ACUTE CARE HOSPITALS

Section 2. Reimbursement for Acute Care Services in Acute Care Hospitals

An acute care hospital shall be paid for an inpatient acute care service on a fully prospective per discharge basis for the universal rate year beginning on or after April 1, 2003.

For an inpatient acute care service in an acute care hospital, the total per discharge payment shall be the sum of:

(a) An operating payment amount;

(b) A capital-related payment amount; and

(c) If applicable, a cost outlier payment amount.

An operating payment amount shall be based on a patient's DRG classification, as assigned by the Medicare DRG classification system. The operating payment amount shall be calculated for each discharge by multiplying a hospital's operating base rate by the Medicaid-specific DRG relative weight. The operating base rate for each hospital shall be the Medicare national standardized amount, as adjusted by Medicare for each hospital using the Medicare wage index and Medicare indirect medical education operating adjustment factor.

The adjusted Medicare national standardized amounts shall be calculated based on the Medicare rate data published in the Federal Register for Medicare payments effective on October 1 of the year immediately preceding the universal

rate year. Data not specifically available in the Federal Register shall be obtained from each hospital's Medicare Fiscal Intermediary.

A capital-related payment amount shall be based on a patient's DRG classification, as assigned by the Medicare DRG classification system. The capital payment amount shall be calculated for each discharge by multiplying a hospital's capital-related base rate by the Medicaid-specific DRG relative weight. The capital-related base rate for each hospital shall be the Medicare federal capital rate, as adjusted by Medicare for each hospital using the Medicare large urban-area adjustment factor if applicable, the Medicare geographic adjustment factor, and the Medicare indirect medical education capital adjustment factor published in the Federal Register.

The adjusted Medicare federal capital rate shall be calculated based on the Medicare rate data published in the Federal Register for Medicare payments effective on October 1 of the year immediately preceding the universal rate year. Data not specifically available in the Federal Register shall be obtained from each hospital's Medicare Fiscal Intermediary.

Kentucky Medicaid-specific DRG relative weights shall be calculated using all applicable Medicaid discharges from the hospital's base year claims data and determined as follows:

(a) Medicaid claims from the base year claims data shall be assigned Medicare DRG classifications using the Medicare DRG classification system.

## SECTION 2. REIMBURSEMENT FOR ACUTE CARE SERIVCES IN ACUTE CARE HOSPITALS

(b) Claims data for discharges that are reimbursed on a per diem basis shall be removed, including:

1. Psychiatric claims from all hospitals, identified as those claims from acute care hospitals for patients with psychiatric diagnoses;

2. All claims from psychiatric hospitals;

3. All claims from rehabilitation hospitals;

4. All claims from critical access hospitals; and

5. All claims from long-term acute care hospitals.

(c) Claims for transplant services shall be removed.

(d) Claims for patients discharged from out-of-state hospitals shall be removed.

(e) Allowed days for the remaining discharges shall be identified.

(f) A unique set of DRGs and relative weights shall be established for a facility identified by the department as qualifying as a Level III Neonatal Center.

1. A claim classified into DRGs 385 through 390 for a qualifying hospital where care is provided in a neonatal intensive care unit bed shall be identified and reassigned to DRGs 685 through 690, respectively.

2. Only a qualifying hospital shall be eligible for payment using DRGs 685 through 690.

(g) A statewide Medicaid arithmetic mean length-of-stay per discharge shall be determined for each DRG classification.

## SECTION 2. REIMBURSEMENT FOR ACUTE CARE SERIVCES IN ACUTE CARE HOSPITALS

(h) Relative weights shall be calculated for each DRG by multiplying the Medicare relative weight by the ratio of the Medicaid arithmetic mean length-of-stay to the Medicare arithmetic mean length-of-stay, and then multiplying by the budget neutrality factor.

(i) For purposes of calculating the DRG relative weights in paragraph (h) of this subsection, Medicare DRG relative weights and arithmetic mean length-of-stay shall be those published in the Federal Register effective on October 1 of the year immediately preceding the universal rate year.

An indirect medical education adjustment factor shall be the same indirect medical education factor used by Medicare for Medicare rates effective on October 1 of the year immediately preceding the universal rate year. An indirect medical education operating adjustment factor shall be the same used by Medicare, based on the published Medicare formula. The ratio of intern and residents to available beds used in the Medicare formula shall be obtained from each hospital's Medicare Fiscal Intermediary.

An indirect medical education capital adjustment factor shall be the same used by Medicare, based on the published Medicare formula. The ratio of intern and residents to average daily census used in the Medicare formula shall be obtained from each hospital's Medicare Fiscal Intermediary.

A kidney, cornea, pancreas, or kidney and pancreas transplant shall be reimbursed on a prospective per discharge method according to the patient's

## SECTION 2. REIMBURSEMENT FOR ACUTE CARE SERIVCES IN ACUTE CARE HOSPITALS

DRG classification. All other transplants shall be reimbursed in accordance with 907 KAR 1:350.

Payment for a federally-defined hospital swing bed shall be made in accordance with 907 KAR 1:065.

## SECTION 3. OUTLIER PAYMENTS

Section 3. Outlier Payments

An additional cost outlier payment shall be made for an approved discharge meeting the Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to QIO review and approval.

A discharge shall qualify for an additional cost outlier payment if its estimated cost exceeds the DRG's outlier threshold. The estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, shall be calculated by multiplying the sum of the hospital-specific Medicare operating and capital-related cost-to-charge ratios by the discharge allowed charges.

The Medicare operating and capital-related cost-to-charge ratios shall be those used by Medicare published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.

An outlier threshold shall be calculated as the sum of the discharge's operating payment amount, capital-related payment amount and the fixed loss cost threshold.

Payment for a cost outlier shall be eighty (80) percent of the amount that estimated costs exceed the discharge's outlier threshold.

## SECTION 4. TRANSFERS

Section 4. Transfers

If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.

For a service reimbursed on a prospective discharge basis, the transfer payment amount shall be calculated based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

An average daily rate shall be calculated by dividing the allowable per discharge reimbursement amount, based on a patient's DRG classification, by the statewide Medicaid average length-of-stay for a patient's DRG classification.

An allowable per discharge reimbursement amount, based on a patient's DRG classification, shall be the sum of the operating payment amount and the capital-related payment amount.

Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount.

For a hospital receiving a transferred patient, reimbursement shall be the allowable per discharge reimbursement amount, based on the patient's DRG classification, and, if applicable, a cost outlier payment amount.

A transfer from an acute care hospital to a qualifying postacute care

## SECTION 4. TRANSFERS

facility for selected DRGs will be treated as a postacute care transfer.

The following shall qualify as a postacute care setting:

1. A psychiatric, rehabilitation, children's, long-term, or cancer hospital;
2. A skilled nursing facility; or
3. A home health agency.

The following DRGs shall be eligible for the postacute care transfer payment:

1. DRG 14, Specific cerebrovascular disorders except transient ischemic attack;
2. DRG 113, Amputation for circulatory system disorders except upper limb and toe;
3. DRG 209, Major joint limb reattachment procedures of lower extremity;
4. DRG 210, Hip and femur procedures except major joint procedures age > seventeen (17) with CC;
5. DRG 211, Hip and femur procedures except major joint procedures age > seventeen (17) without CC;
6. DRG 236, Fractures of hip and pelvis;
7. DRG 263, Skin graft and debridement for skin ulcer or cellulitis with CC;
8. DRG 264, Skin graft and debridement for skin ulcer or cellulitis without CC;

## SECTION 4. TRANSFERS

9. DRG 429, Organic disturbances and mental retardation; and

10. DRG 483, Tracheostomy except for face, mouth and neck diagnoses.

Each transferring hospital is paid a per diem rate for each day of stay. No payments are to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

1. DRGs 209, 210, and 211 shall receive fifty (50) percent of the full DRG payment plus the per diem for the first day of the stay and fifty (50) percent of the per diem for the remaining days of the stay, up to the full DRG payment.

2. The remaining DRGs as referenced in paragraph (a) of this subsection shall receive twice the per diem rate the first day and the per diem rate for each following day of the stay prior to the transfer.

The per diem amount shall be the full DRG payment allowed divided by the statewide Medicaid average length of stay for that DRG.

Effective February 1, 2004, an intra-hospital transfer to or from an acute care bed to or from a Medicare designated rehabilitation or psychiatric distinct part unit shall be reimbursed both the full DRG payment allowed and the facility-specific distinct part unit per diem rate for each day the recipient is an inpatient in the distinct part unit.

# SECTION 5. REIMBURSEMENT FOR REHABILITATION SERVICES IN AN ACUTE CARE HOSPITAL

Section 5. Payment for Rehabilitation Services in an Acute Care Hospital.

Effective February 1, 2004, a rehabilitation service in an acute care hospital that has a Medicare designated rehabilitation distinct part unit shall be reimbursed on a per diem basis. The per diem rate will be a facility-specific rate based on the most recently received cost report.

A rehabilitation service provided in a hospital that does not have a Medicare designated distinct part unit will be reimbursed the median of rehabilitation services provided in all acute care hospitals.

# SECTION 6. REIMBURSEMENT FOR INPATIENT PSYCHIATRIC SERVICES IN ACUTE CARE HOSPITALS

Section 6. Payment for Inpatient Psychiatric Services in Acute Care Hospitals

An acute care hospital shall be reimbursed for an inpatient psychiatric service on a per diem basis for the universal rate year beginning on or after April 1, 2003.

Effective February 1, 2004, an inpatient psychiatric service provided in an acute care hospital that has a Medicare designated psychiatric distinct part unit shall be reimbursed on a per diem basis.

Reimbursement for an inpatient psychiatric service shall be determined by multiplying a hospital's psychiatric per diem rate by the number of allowed patient days. The psychiatric per diem rate for an acute care hospital shall be the sum of the psychiatric operating per diem rate and the psychiatric capital per diem rate.

For an acute care hospital having licensed psychiatric beds in accordance with 902 KAR 20:180, the psychiatric operating per diem rate shall be the facility-specific psychiatric operating cost per day, adjusted by the budget neutrality factor.

The psychiatric operating cost per day amounts used to determine the psychiatric operating per diem rate shall be calculated for each hospital by dividing its Medicaid psychiatric cost basis, excluding capital costs and medical education costs, by the number of Medicaid psychiatric patient days in the base

## SECTION 6. REIMBURSEMENT FOR INPATIENT PSYCHIATRIC SERVICES IN ACUTE CARE HOSPITALS

year.

The Medicaid psychiatric cost basis and patient days shall be based on Medicaid claims for patients with a psychiatric diagnosis with dates of service in the base year. The psychiatric operating per diem rate shall be adjusted for:

1. The price level increase from the mid-point of the base year to the mid-point of the universal rate year using the CMS Input Price Index; and

2. The change in the Medicare published wage index from the base year to the universal rate year.

For an acute care hospital having licensed psychiatric beds in accordance with 902 KAR 20:180, the psychiatric capital per diem rate shall be the lesser of a facility-specific psychiatric capital cost per day or the median of all psychiatric services in an acute care hospital.

For an acute care hospital without licensed psychiatric beds, the psychiatric capital per diem rate shall be the median rate for all licensed psychiatric beds as described in Section 10(3)(a) of 907 KAR 1:013.

A psychiatric capital per diem rate shall be the lesser of a facility-specific rate or the median of all psychiatric services in an acute care hospital. The facility-specific rate shall be calculated for each hospital by dividing its Medicaid psychiatric capital cost basis by the number of Medicaid psychiatric patient days in the base year. The Medicaid psychiatric capital cost basis and patient days

## SECTION 6. REIMBURSEMENT FOR INPATIENT PSYCHIATRIC SERVICES IN ACUTE CARE HOSPITALS

shall be based on Medicaid claims for patients with psychiatric diagnoses with dates of service in the base year.

For psychiatric services in an acute care hospital that does not have a Medicare designated distinct part unit, the psychiatric per diem rate shall be the median rate for all psychiatric services in acute care hospitals.

## SECTION 7. BUDGET NEUTRALITY

Section 7. Budget Neutrality

When rates are rebased, estimated projected reimbursement in the universal rate year for hospitals shall not exceed payments for the same services in the prior year adjusted for inflation using the CMS Input Price Index, and changes in patient utilization.

The estimated total payments for each facility under the reimbursement methodology in effect in the year prior to the universal rate year shall be estimated for base year claims. Amounts shall be adjusted for changes in inflation using the CMS Input Price Index, patient utilization, and other variables identified by the department which affect reasonable reimbursement levels.

The estimated total payments for each facility under the reimbursement methodology in effect in the universal rate year shall be estimated for base year claims.

If the sum of all the acute care hospitals estimated payments under the methodology used in the universal rate year exceeds the sum of all the acute care hospitals adjusted estimated payments under the prior year's reimbursement methodology, the following universal rate year reimbursement components shall be adjusted and shall result in estimated payments that are budget neutral:

(a) DRG relative weights; and

(b) Periodic direct graduate medical education payment amounts.

## SECTION 8. REIMBURSEMENT UPDATING PROCEDURES

Section 8. Reimbursement Updating Procedures

The department shall rebase per discharge base rates, per diem rates, DRG relative weights, and other applicable components of the payment rates no less frequently than every three (3) years using the most recent audited cost report and Medicare rate data available to the department. Applicable components shall include:

(a) Operating rates;

(b) Capital-related rates;

(c) Medical education costs;

(d) Cost-to-charge ratios;

(e) DRG relative weights; and

(f) Outlier thresholds.

Beginning July 1, 2004, the department shall adjust rates annually on July 1 using the Medicare DRG base rate in effect October 1 of the preceding year as published in the Federal Register and confirmed with the Fiscal Intermediary. The department shall adjust per diem rates annually according to the following:

(a) A psychiatric operating per diem rate shall be inflated from the mid-point of the previous universal rate year to the mid-point of the current universal rate year using the CMS Input Price Index; and

(b) A capital cost per diem and psychiatric capital per diem rate shall not be adjusted.

## SECTION 8. REIMBURSEMENT UPDATING PROCEDURES

Except for an appeal no other adjustment shall be made.

## SECTION 9. PAYMENT FOR REHABILITATION HOSPITAL, LONG-TERM ACUTE CARE HOSPITAL, AND PSYCHIATRIC HOSPITALS

Section 9. Payment for Rehabilitation Hospital, Long-term Acute Care Hospital, and Psychiatric Hospitals.

An inpatient service provided to an eligible Medicaid recipient in a rehabilitation hospital, LTAC hospital, or psychiatric hospital shall be reimbursed at the per diem rate in effect for the rate year beginning July 1, 2002.

An inpatient service provided to an eligible Medicaid recipient shall be reimbursed by multiplying the hospital's per diem rate by the number of patient days.

A psychiatric hospital shall:

(a) Except as provided in paragraph (b) or (c) of this subsection, have an upper payment limit established on allowable Medicaid costs (except Medicaid capital costs and professional component costs) at the weighted median per diem cost for a hospital in its array;

(b) If the hospital has Medicaid utilization of thirty-five (35) percent or higher, have an upper limit set at 115 percent of the weighted median per diem cost for a hospital in its array; or

(c) Be exempt from the upper payment limit for its array if designated by the department as a primary referral and service resource for a child in the custody of the Cabinet for Families and Children and be paid at projected actual cost as follows:

## SECTION 9. PAYMENT FOR REHABILITATION HOSPITAL, LONG-TERM ACUTE CARE HOSPITAL, AND PSYCHIATRIC HOSPITALS

1. Projected actual cost shall be determined by:

a. The Medicare and Medicaid cost reports supplemented by any expenditures allowed on the Medicaid cost report incurred since the filing of the cost report; and

b. Projected additional expenditures for the rate year;

2. Projected additional expenditures for the rate year not subsequently incurred shall be subject to a cost settlement based on actual expenditures allowed on a Medicaid cost report; and

3. The cost determined in subparagraph 1a of this paragraph shall be adjusted for inflation using the DRI index.

If a desk review or audit of the most current cost report is complete after May 1 but prior to the universal rate setting for the year, the desk review or audited data shall be utilized for rate setting.

An array or an upper payment limit shall not be altered after being set by the department.

Professional component costs shall be trended and indexed separately in the same manner as operating costs, except an upper payment limit shall not be established.

Beginning July 1, 2004, the department shall adjust per diem rates annually on July 1 using the most recent cost report.

## SECTION 10. PAYMENT FOR A CRITICAL ACCESS HOSPITAL

Section 10. Critical Access Hospital.

The department shall pay for an inpatient service provided by a critical access hospital to an eligible Medicaid recipient through an interim per diem rate as established by the Centers for Medicare and Medicaid Services (CMS) for the Medicare Program. The effective date of a rate shall be the same as used by the Medicare Program.

A critical access hospital shall be required to submit an annual Medicare/Medicaid cost report. The cost report shall be subject to audit and review. Total payments made to a hospital under this section shall be subject to the payment limitation in 42 CFR 447.271.

Payment for a federally defined swing bed in a critical access hospital shall be made in accordance with 907 KAR 1:065.

# SECTION 11. REIMBURSEMENT FOR OUT-OF-STATE HOSPITALS

Section 11. Reimbursement for Out-of-state Hospitals

An acute care out-of-state hospital shall be reimbursed for an inpatient acute care service and an inpatient rehabilitation service on a fully prospective per discharge basis for the universal rate year beginning on or after April 1, 2003. The total per discharge reimbursement shall be the sum of an operating payment amount, a capital-related payment amount, and, if applicable, a cost outlier payment amount.

The operating payment amount shall be based on the patient's Medicare DRG classification. An operating payment amount shall be calculated for each discharge by multiplying a hospital's operating base rate by the Kentucky-specific DRG relative weight. A hospital's operating base rate shall be the Medicare national standardized amount, as adjusted by Medicare for each hospital using the Medicare wage index. Amounts for out-of-state providers shall exclude:

1. The Medicare DSH operating adjustment factor; and
2. The Medicare indirect medical education operating adjustment factor.

The capital-related payment amount shall be made on a per discharge basis. A per discharge payment amount shall be calculated for each discharge by multiplying a hospital's capital-related base rate by the Kentucky-specific DRG relative weight. A hospital's capital-related base rate shall be the Medicare federal capital rate, as adjusted by Medicare for each hospital using the Medicare

## SECTION 11. REIMBURSEMENT FOR OUT-OF-STATE HOSPITALS

large urban-area adjustment factor when applicable and the Medicare geographic adjustment factor as published in the Federal Register. Amounts for out-of-state providers shall exclude:

1. The Medicare DSH capital adjustment factor; and
2. The Medicare indirect medical education capital adjustment factor.

A cost outlier payment shall be made for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to QIO review and approval.

1. The cost outlier threshold for out-of-state claims shall be determined using the same method used to determine the cost outlier threshold for in-state claims.
2. The estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, shall be calculated by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge allowed charges.
3. The outlier payment amount shall be eighty (80) percent of the amount that estimated costs exceed the discharge's outlier threshold.

An acute care out-of-state hospital shall be reimbursed for an inpatient psychiatric service on a fully prospective per diem basis for the universal rate

## SECTION 11. REIMBURSEMENT FOR OUT-OF-STATE HOSPITALS

year beginning on or after April 1, 2003.

Reimbursement for an inpatient psychiatric service shall be determined by multiplying a hospital's psychiatric per diem rate by the number of allowed patient days. A psychiatric per diem rate shall be the sum of a psychiatric operating per diem rate and a psychiatric capital per diem rate.

The psychiatric operating and capital per diem rate shall be the median operating cost, excluding graduate medical education, per day for all acute care in-state hospitals that have licensed psychiatric beds according to 902 KAR 20:180.

Reimbursement for a service in an out-of-state rehabilitation hospital shall be determined by multiplying a hospital's rehabilitation per diem rate by the number of allowed patient days. A rehabilitation per diem rate shall be the median rehabilitation per diem rate for all in-state rehabilitation hospitals.

Reimbursement for a service in an out-of-state psychiatric hospital shall be determined by multiplying a hospital's psychiatric per diem rate by the number of allowed patient days. Reimbursement for a psychiatric service in an out-of-state acute care hospital shall be the hospital's psychiatric per diem rate by the number of allowed patient days.

The department shall apply the requirements of 42 CFR 447.271 on a claim-specific basis to payments made under this Section.

## SECTION 12. SUPPLEMENTAL PAYMENTS

Section 12. Supplemental Payments.

In addition to a payment based on a rate, the department shall make quarterly supplemental payments to A hospital that qualifies as a nonstate pediatric teaching hospital in an amount:

1. Equal to the sum of the hospital's Medicaid shortfall for Medicaid recipients under the age of eighteen (18) plus an additional $250,000 ($1,000,000 annually); and

2. Prospectively determined by the department with an end of the year settlement based on actual patient days of Medicaid recipients under the age of eighteen (18).

A supplemental payment shall also be made to a hospital that qualifies as a pediatric teaching hospital and additionally meets the criteria of a Type III hospital in an amount:

1. Equal to the difference between payments made in accordance with Sections 3, 4, 5, and 6 of this administrative regulation and the amount allowable under 42 CFR 447.272, not to exceed the payment limit as specified in 42 CFR 447.271;

2. That is prospectively determined with no end of the year settlement; and

3. Based on the state matching contribution made available for this purpose by a facility that qualifies under this paragraph.

## SECTION 12. SUPPLEMENTAL PAYMENTS

A supplemental payment shall be made to a hospital that qualifies as an urban trauma center hospital in an amount:

1. Based on the state matching contribution made available for this purpose by a government entity on behalf of a facility that qualifies under this paragraph;

2. Based upon a hospital's proportion of Medicaid patient days to total Medicaid patient days for all hospitals that qualify under this paragraph;

3. That is prospectively determined with an end of the year settlement; and

4. That is consistent with the requirements of 42 CFR 447.271.

A supplemental payment shall be made to a hospital that qualifies as a psychiatric access hospital in an amount:

1. Equal to a hospital's uncompensated costs of providing services to Medicaid recipients and individuals not covered by a third-party payor, not to exceed $6 million annually; and

2. That is consistent with the requirements of 42 CFR 447.271.

A supplemental payment shall be made to a nonstate government-owned hospital as defined in 42 CFR 447.272(a)(2) that has entered into an intergovernmental transfer agreement with the Commonwealth in an amount equal to the lessor of:

## SECTION 12. SUPPLEMENTAL PAYMENTS

1. The difference between the payments made in accordance with this reimbursement manual and the maximum amount allowable under 42 CFR 447.272; or

2. The difference between the payments made in accordance with this reimbursement manual and an amount consistent with the requirements of 42 CFR 447.271.

A supplemental payment shall be made to a private, nongovernment owned or operated hospital in an amount:

1. Proportional to its Medicaid cost as compared to the total Medicaid costs of all hospitals qualifying under this paragraph;

2. Not to exceed its Medicaid shortfall; and

3. Subject to available funds in accordance with an intergovernmental transfer agreement of this subsection and 907 KAR 1:015. Available funds shall be:

a. An amount equal to fifty (50) percent of the payments received by hospitals after deducting the nonfederal share of the funds, less the total Medicaid shortfall of hospitals participating; and

b. Matched with federal funds.

An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility.

## SECTION 12. SUPPLEMENTAL PAYMENTS

For the purpose of this section, Medicaid patient days shall not include days for a Medicaid recipient eligible to participate in the state's Section 1115 waiver as described in 907 KAR 1:705.

A payment made under this section shall not duplicate a payment made under Section 22 of 907 KAR 1:013 and shall be in compliance with the limitations in 42 CFR 447.272.

A supplemental payment for DRGs 385 through 390 shall be made to a hospital with a Level II neonatal intensive care unit that meets the following qualifications:

(a) Is licensed for a minimum of 24 neonatal level II beds;

(c) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;

(d) Has a gestational age lower limit of twenty-seven (27) weeks; and

(e) Has a full-time perinatologist on staff.

The payment shall be an additional payment of $3,775 added on per admission to the neonatal intensive care unit (NICU) for each allowed DRG.

For dates of service beginning December 1, 2003, a supplemental Medicaid shortfall DSH payment shall be added per paid claim for inpatient hospital services in an acute care hospital reimbursed on a DRG basis. The supplemental payment will remain in effect until whichever of the following occurs first:

## SECTION 13. DISPROPORTIONATE SHARE HOSPITAL CLASSIFICATION

Section 13. Disproportionate Share Hospital Classification

Except as otherwise specified in this section, classification of disproportionate share hospitals shall be made prospectively prior to the beginning of each universal rate year. Classification, once determined by the department, shall not be revised for that rate year except that for psychiatric hospitals not previously determined to meet disproportionate share hospital status due to failure to meet the one (1) percent minimum Medicaid occupancy requirement, the department shall also accept no more frequently than once each calendar year a patient census submitted by the hospital showing adequate Medicaid occupancy with the subsequent classification to be effective for the balance of the calendar year.

Psychiatric hospitals with Medicaid utilization of thirty-five (35) percent or higher shall have an upper limit set at 115 percent of the weighted median per diem cost for psychiatric hospitals in the array.

# SECTION 14. NEW PROVIDERS, CHANGE OF OWNERSHIP, OR MERGED FACILITIES

Section 14. New Providers, Change of Ownership, or Merged Facilities

A. CHANGE OF OWNERSHIP

If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the prospective rate in effect.

B. NEWLY CONSTRUCTED OR NEWLY PARTICIPATING HOSPITALS

Until a fiscal year end cost report is available, newly constructed or newly participating hospitals shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification. A prospective rate shall be set based on this data, not to exceed the upper limit for the class. This prospective rate shall be tentative and subject to settlement at the time the first audited fiscal year end report is available to the department. During the projected rate year, the budget can be adjusted if indicated, and justified by the submittal of additional information.

C. MERGED FACILITIES

In the case of two (2) separate entities that merge into one (1) organization, the department shall:

1. Merge the latest available data used for rate setting;
2. Combine bed utilization statistics, creating new occupancy ratios;
3. Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs;

## SECTION 14. NEW PROVIDERS, CHANGE OF OWNERSHIP, OR MERGED FACILITIES

4. Compute on a weighted average the rate of increase control applicable to each entity, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting;

5. If one (1) of the entities merging has disproportionate status and the other does not, retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid;

6. Recognize appeals of the merged per diem rates in accordance with 907 KAR 1:671; and

7. Require each provider to submit a "Close of Business" Medicaid cost report for the period ended as of the day before the merger. This report shall be due from the provider within the time frame outlined in Section 16 of this manual. Medicaid cost reports for the period starting with the day of the merger and ending on the fiscal year end of the merged entity shall also be filed with the department in accordance with Section 16 of this manual.

## SECTION 15. UNALLOWABLE COSTS

Section 15. Unallowable Costs

The following costs shall not be considered allowable costs for Medicaid reimbursement:

1. Costs associated with political contributions;
2. The cost associated with legal fees for unsuccessful lawsuits against the cabinet. Legal fees relating to lawsuits against the cabinet shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and
3. The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities. However, costs (excluding transportation costs) for training or education purposes outside the Commonwealth of Kentucky shall be allowable costs. If these meetings are not educational, the cost (excluding transportation) shall be allowable if educational or training components are included.

Since the costs referenced in this section are currently not identified by the Medicare or Medicaid cost report, hospitals shall identify these unallowable costs

on the Supplemental Medicaid Schedule KMAP-1. The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report. The purpose of the Supplemental Medicaid Schedule KMAP-1 is to identify these unallowable costs for exclusion from the prospective rate computation.

## SECTION 16. COST REPORTING REQUIREMENTS

Section 16. Cost Reporting Requirements

Each hospital participating in the program shall submit an annual cost report (HCFA 2552), including the Supplemental Medicaid Schedules, in the manner prescribed by the program as follows:

A. The reports shall be filed for the fiscal year used by the hospital;

B. The cost report shall be submitted within five (5) months after the close of the hospital's fiscal year; and

C. An extension shall not be granted by the program except in instances as follows:

1. When Medicare grants an extension, the Medicaid cost report shall be required simultaneous to the submittal of the Medicare cost report; or

2. When, catastrophic circumstances exist such as floods, fires or other equivalent occurrences, an additional 30 days for filing the cost report may be granted by the program;

B. If the filing date lapses and no extension has been granted, the program shall immediately suspend all payments to the hospital until an acceptable cost report is received.

# SECTION 17. ACCESS TO SUBCONTRACTOR'S RECORDS

Section 17. Access to Subcontractor's Records

If the hospital has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for services costing or valued at $10,000 or more over a twelve (12) month period, the contract shall contain a clause giving the department access to the subcontractor's books. Access shall also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor. The contract shall contain a provision allowing access in accordance with 907 KAR 1:672.

# SECTION 18. AUDIT FUNCTION

## Section 18. Audit Function

After the hospital has submitted the annual cost report, the program shall perform a limited desk review. The purpose of a desk review is to verify prior year cost to be used in setting the prospective rate. The Medicare intermediary shall be informed of any findings as a result of this desk review. Under a common audit agreement, the Medicare intermediary provides Medicaid with copies of any audits performed by Medicare (Title XVIII). However, the program may choose to audit even though Medicare does not.

## SECTION 19. RETROSPECTIVE REVIEW

Section 19. Retrospective Review.

A claim paid in accordance with the DRG reimbursement methodology shall be subject to retrospective review by the QIO.

An amount paid that has been found to be paid in error shall be recouped by the department in the next payment cycle. A payment that has been recouped by the department shall not be subject to administrative review.

## SECTION 20. REIMBURSEMENT REVIEW APPEAL PROCEDURES

Section 20. Reimbursement Review Appeal Procedures

An administrative review shall not be available for the following:

a. A determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rate;

b. The establishment of:

1. Diagnosis related groups (DRGs);

2. The methodology for the classification of an inpatient discharge within each DRG; or

3. Appropriate weighting factors that reflect the relative hospital resources used with respect to discharge within each DRG.

An administrative review shall not be available for facilities or services reimbursed under the per diem methodology for the determination of the requirement, or the proportional amount, of any budget neutrality adjustment used in the calculation of the per diem rate.

Administrative review is available for calculation errors in the establishment of the per diem rate.

An appeal shall following the review and appeal mechanism established in 907 KAR 1:671.

## SECTION 21. KCHIP OR MEDICAID SCREENING FORM (DSH-001)

Section 21. Supplemental Medicaid Schedules and Instructions

This section contains the screening form to be used by the provider to assess the patient's financial situation to determine if Medicaid or Kentucky Children's Health Insurance Program (KCHIP) may cover hospital expenses in accordance with Section 23 of 907 KAR 1:013.

**DSH-001** *(Rev. 03/03)*

# APPLICATION FOR DISPROPORTIONATE SHARE HOSPITAL PROGRAM (DSH)

## SECTION I. Individual Information

The following information is required to determine if an individual who requests or has already received hospital services is eligible for Disproportionate Share Hospital services or should be referred to the Department for Community Based Services (DCBS) to officially apply for Medicaid or KCHIP. Refer **all uninsured children aged 19 and under** to the DCBS office in the county of the individual's residence for a KCHIP eligibility determination.

1. Today's Date:_____

2. Patient Name:_____

3. Street Address:_____

4. City:_____ State:_____ Zip Code:_____

5. Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐

6. Date of Birth: ____/___/_____ 7. Patient Sex:_____

8. Home Phone: _____ 9. Work Phone:_____

10. Date(s) hospital services provided: ____/___ /_____ - ____/____/____

11. Married/Single:_____ 12. Name of Spouse:_____

13. Is the patient pregnant? ☐ Yes ☐ No. If yes, refer the patient to DCBS for a Medicaid eligibility determination.

14. Is the patient a resident of Kentucky?
*"RESIDENT" IS DEFINED AS A PERSON LIVING IN KENTUCKY AND WHO IS NOT RECEIVING PUBLIC ASSISTANCE IN ANOTHER STATE.*
Yes ☐ No☐

If the answer to question 14 is **yes**, go to question 15. If the answer to question 14 is **no**, **advise the patient that he/she does not meet criteria for eligibility for DSH and complete Section V.**

15. List the name, social security no., relationship, and age of each person living in the household.

**Household Members**

| Name | Social Security # | Relationship | Age |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

16. Does the individual have dependent children living in the home ? Yes ☐ No ☐

(a) **If the answer to question 16 is YES**, refer the individual to DCBS for Medicaid;

(b) If the answer to question 16 is **NO**, refer the individual to DCBS for Medicaid **ONLY IF** the individual has **NOT** received a denial from Medicaid within 30 days; **or,**

(c) If the- individual who has no children less than 18 years of age, claims to be **disabled**, **refer** the individual to the **Social Security Administration** to apply for SSI.

## 17. Income Information:

Patient/Responsible Party Employer_____
Spouse Employer_____
Work Phone_____
Total Gross Monthly Income:_____
Other Income:
Unemployment_____Child Support_____
Soc. Sec._____ Workers Comp_____
SSI_____Other_____

**Total Family Unit Gross Monthly Income: $_____**

## 18. Insurance Information:

Health/Life Insurance:_____ Phone#_____

Policy #_____Group#_____

Policy Holder_____Relation to Patient_____

19. List the patient's countable resources below. Countable resources include: a checking account, savings account, stock, bond, mutual fund, certificate of deposit, money market account.

### Countable Resources

| | Bank Name | Balance/Value |
|---|---|---|
| Checking | | |
| Savings | | |
| Certificate<br>Of deposit | | |
| Money market | | |
| Mutual fund | | |
| Stocks | | |
| Bonds | | |
| Other | | |

***Total Health Bills Owed: $_____**
**Total Resource: $_____**
***Note**: COUNTABLE RESOURCES SHALL BE REDUCED BY UNPAID MEDICAL EXPENSES OF THE FAMILY UNIT TO ESTABLISH ELIGIBILITY.

## Other Information:

Was date of service related to an auto accident?_____

**SECTION II. Hospital Indigent Care Criteria**

(1) An individual must meet all of the following conditions:
(a) The individual is a resident of Kentucky.
(b) The individual is **not eligible** for Medicaid.
(c) The individual is **not** covered by a 3rd party payor.
(d) The individual is **not** in the custody of a unit of government which is responsible for coverage of the acute care needs of the individual.
(e) The individual meets the following income and resource criteria:

| Household Size | Resource Limit | 100% of the Poverty Level (Monthly Income Limit)* | 100% of the Poverty Level (Annual Income Limit)* |
|---|---|---|---|
| 1 | $2,000.00 | $748.33 | $ 8,980.00 |
| 2 | $4,000.00 | $1,010.00 | $12,120.00 |
| 3 | $4,050.00 | $1,271.67 | $15,260.00 |
| 4 | $4,100.00 | $1,533.33 | $18,400.00 |
| 5 | $4,150.00 | $1,795.00 | $21,540.00 |

***Note- Income limits are effective March 1, 2003**
(2) **All income** of a family unit is to be counted and a family unit includes:
(a) The individual;
(b) The individual's spouse who lives in the home;
(c) A parent or parents, of a minor child, who lives in the home;
(d) All minor children who live in the home.
(3) Related and nonrelated household member(s) who do not fall into one of the groups listed above shall be considered a separate family unit.
(4) **Countable resources are limited to** cash, checking and savings accounts, stocks, bonds, certificates of deposit, and money market accounts.
(5) Countable resources may be reduced by unpaid medical expenses of the family unit to determine eligibility.

**SECTION III. Certifying Accuracy of Information**

I hereby agree to furnish the Hospital all necessary information to allow them to determine my need to receive financial assistance for health care services received. I agree that the Hospital will be provided with or may obtain all documents necessary to verify my current income, employment status, and resources, and that failure to supply requested information within **ten** (10) working days is grounds for denial of my application for assistance. I also agree to notify the Hospital immediately of any change of address, telephone number, employment status, or income.

I agree to allow the Hospital representative to determine eligibility and pursue state and federal assistance with Medicaid, KCHIP and DSH.

I certify that the information provided on this application is correct to the best of my knowledge and belief. I understand that if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I understand that I have a right to request a fair hearing if I am dissatisfied with any action taken on my application. I understand that I must contact the hospital to make a hearing request.

Individual or Responsible Party's Signature _____ Date _____

Hospital Employee Signature _____ Date _____

Does the individual appear to qualify for Medicaid or KCHIP? Yes ☐ No ☐

**If yes, then refer the individual to the DCBS office in the county of the individual's residence. The individual should take a copy of this form with him/her to the DCBS office.**

**SECTION IV. Refusal to Apply for Medicaid**

The individual or his responsible party shall sign below if he refuses to apply for Medicaid.

I refuse to apply for Medicaid or KCHIP coverage. I understand that this refusal may result in me being billed for any services performed.

Individual or Responsible Party's Signature _____ Date _____

**SECTION V. Indigent Care Denial**

The individual does not meet the criteria for indigent care. The individual may request a fair hearing regarding this determination within 30 days of this determination. The hospital shall conduct a fair hearing within 30 days of receiving the individual's hearing request.

Hospital Employee Signature _____ Date _____

**RETAIN A COPY OF THIS APPLICATION IN THE PATIENT'S RECORDS.**
**THIS DETERMINATION IS VALID FOR A PERIOD OF SIX MONTHS UNLESS THE INDIVIDUAL'S FINANCIAL SITUATION CHANGES.**